

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

45th 3/11/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>44E208</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/26/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHARTON NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>55 WEST LAKE ROAD PLEASANT HILL, TN 38578</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	<p><b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:            Identification and demographic information;            Customary routine;            Cognitive patterns;            Communication;            Vision;            Mood and behavior patterns;            Psychosocial well-being;            Physical functioning and structural problems;            Continence;            Disease diagnosis and health conditions;            Dental and nutritional status;            Skin conditions;            Activity pursuit;            Medications;            Special treatments and procedures;            Discharge potential;            Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and            Documentation of participation in assessment.</p>	F 272	<p><b>Incontinent assessment:</b>            A 72 hour incontinence assessment will be completed by the LPN charge nurses and CNA's for resident #44 on 2-12-12. Urinary/bladder patterns, if any, will be determined and resident will be started on an appropriate bladder maintenance or retraining program.</p> <p>An audit will be completed by the LPN charge nurses on 2-12-12 to identify any resident with a change and/or decline in continence. A 72 hour incontinence assessment will be completed by 3-1-12 and appropriate interventions initiated on all residents found to have a change in bladder continence.</p> <p>The DON, ADON and staff development coordinator will complete education to RN/LPN CNA staff by and on reporting and documentation of changes in bladder continence. The MDS coordinator will reassess all residents at admission, quarterly and with any significant change in condition including, but not limited to, change in continence to ensure that each resident's</p>	2-12-12 2-12-12 3-1-12 3-1-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert Gray</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2-10-12</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to complete an incontinence assessment for one (#44) of one sampled resident with incontinence and failed to perform weekly wound assessments for one (#12) of one sampled resident admitted with wounds of twenty-three residents reviewed in Stage 2.  The findings included:  Resident #44 was admitted to the facility on September 13, 2011, with diagnoses including Urinary Frequency, Atrial Fibrillation, Glaucoma, and Edema.  Review of the Minimum Data Set (MDS) dated December 20, 2011, revealed the resident had frequent urinary incontinence defined by the MDS as having seven or more episodes of urinary incontinence but at least one episode of continence.  Review of the facility policy, Continence Care Management Program, revealed, "...All residents who are incontinent on admission or develop incontinence will be assessed by a registered nurse using the MDS, the Urinary Incontinence RAP (Resident Assessment Protocol), and the restorative nursing toileting assessment...The information from these assessments will be used to determine the type of program that will assist the resident to regain continence or reduce the incidence of incontinence..."	F 272	continued from page 1 functional capacity is met and maintained.  Any resident having a significant change in condition including urinary continence will be presented at the monthly QAA to ensure appropriate assessments were completed and interventions were initiated in a timely manner.  Wound assessment: A wound assessment was completed for resident #12 on 1-31-12 by the LPN charge nurse. The DON educated Home 1 LPN charge nurses on 2-9-12 regarding weekly wound assessments, schedules and proper documentation of wounds.  An audit of documentation for all residents with wounds was completed 2-8-12 by LPN charge nurse to ensure all wound care assessments were current and complete.  The DON will complete education to RN/LPN staff by 3-1-12 to ensure compliance with weekly wound assessments including proper documentation. Weekly wound assessment schedules will be maintained and monitored by the DON and	1-31-12 2-8-12	

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F 272	Continued From page 2  Interview with the resident's spouse on January 25, 2012, at 10:30 a.m., in the resident's room revealed the resident had not been incontinent prior to admission to the facility.  Interview with the Director of Nursing on January 26, 2012, at 11:15 a.m., in the conference room confirmed the facility's policy had not been implemented, and the resident had not been assessed for incontinence management.  Medical record review for Resident #12 documented an admission date of August 18, 2003 and a readmission date of May 31, 2011 with diagnoses of Parkinson's Disease, Pressure Ulcer, Hypothyroidism, Osteoporosis, Esophageal Reflux, and Constipation.  Review of a physician's order dated November 16, 2011 documented, "...Cleanse wound with wound cleaner; pack inner wound with Iodoform packing strip; Apply Triad ointment around outer edges; cover with Optifoam non-adhesive; secure with medipore tape; Change daily AM and as needed..."  Review of the facility's wound assessment policy documented, "THE TX [treatment] NURSE WILL ASSESS ALL WOUNDS Q [every] WEEK AND PRN [as needed]...PUSH [pressure ulcer scale for healing] TOOL AND CARE PLAN WILL BE UPDATED Q WEEK AND PRN. ALL STAGED WOUNDS WILL BE PLACED ON WEEKLY WOUND/PRESSURE ULCER SHEET...ALL RESIDENTS WILL HAVE SKIN ASSESSMENT BY LPN DURING WEEKLY CHARTING..."	F 272	continued from page 2  reviewed on a weekly basis to ensure assessment completion.  All residents with wounds will be presented to the QAA committee monthly and documented weekly assessments will be reviewed at QAA meetings.		

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F 272	<p>Continued From page 3</p> <p>Review of the Nurse's Notes dated June 1, 2011 documented Resident #12 had an area on the right buttock described as, "scuffed off broken skin measuring 1/4 by 1/4..." From June 1, 2011 until June 28, 2011 there was no weekly wound assessment documented.</p> <p>Review of the Nurse's Notes date July 12, 2011 documented, "...AREA 1: right upper buttock...WOUND TYPE: STAGE 4...length (cm) [centimeters] 4.25 width (cm) 4.0 depth .25 cm..." From July 12, 2011 until July 25, 2011 there was no weekly wound assessment documented.</p> <p>Review of the Nurses Notes dated November 12, 2011 documented, "SITE: Right buttock...WOUND TYPE: Stage 4...length (cm) 3 width (cm) 3 depth 3 cm." From November 12, 2011 until December 21, 2011 there was no weekly wound assessment documented.</p> <p>Observations in Resident #12's room on January 26, 2011 at 10:55 am, revealed Resident #12 lying in bed. Nurse #3 removed a dressing from the right buttock of Resident #12. Observation revealed a wound with full thickness skin loss and subcutaneous tissue loss.</p> <p>During an interview in the conference room on January 26, 2012 at 9:20 am, the Staff Development Coordinator was asked what did a weekly wound assessment include. The Staff Development Coordinator stated, "A weekly wound assessment would consist of measurements and a description of the wound. The nurses would use the PUSH tool. It would include the measurements...The policy needs to be updated. The policy is not working for us as</p>	F 272			

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F 272	Continued From page 4 intended. There is confusion with the nurses about the PUSH tool to assess the wound." The Staff Development Coordinator reviewed the Nurse's Notes and confirmed the weekly wound assessments were not completed for Resident #12.  During an interview in the conference room on January 26, 2012 at 9: 25 am, Nurse #3 stated, "We don't use the PUSH tool to assess wounds unless the wound is a Stage 3 or 4 so we didn't have measurements or describe in detail." Nurse #3 confirmed weekly wound assessments were not completed for Resident #12.	F 272					
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	The careplans for residents #8,15,31,23,43 were reviewed and revised by the MDS coor- dinator on 2-9-12 to reflect current, mobility and fall interventions respectively. 2-9-12  The DON and MDS coordinator will complete audit of 10% of residents charts weekly to ensure accuracy and 100% compliance.  All physician's orders will be read and reviewed daily at AM meetings with PCP's updated accordingly to reflect current care.  The MDS Coordinator will present results of PCP(chart) audits to the QAA committee for 3 months.				

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F 280	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to revise the care plan for changes in diet for one resident (#8); with changes in mobility for two residents (#15, #31); and for interventions after falls for two residents (#23, #43) of twenty-three residents reviewed in Stage 2.</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on November 12, 2010, with diagnoses including Dementia, Dyspnea (shortness of breath), Gastro Esophageal Reflux, and Lung Mass.</p> <p>Medical record review of the resident's January 2012, physician's recapitulation orders revealed "...12/19/11 Diet: Pureed no added salt ..."</p> <p>Medical record review of the resident's care plan dated November 23, 2010, and revised on January 23, 2012, revealed "...Provide ordered diet, Mechanical soft No added salt diet..."</p> <p>Observation on January 23, 2012, at 11:55 a.m., January 24, 2012, at 5:00 p.m., and on January 25, 2012, at 5:05 p.m., in the dining room revealed the resident being fed pureed food.</p> <p>Interview on January 27, 2012, at 2:30 p.m., in the Minimum Data Set (MDS) office with the MDS Registered Nurse (RN) Coordinator confirmed the resident's diet order changed on Dec 19, 2011, from mechanical soft to pureed, and the resident's care plan had not revised to reflect the</p>			F 280			

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F 280	<p>Continued From page 6 diet change.</p> <p>Resident #15 was admitted to the facility on October 12, 2010, with diagnoses including Severe Osteoarthritis, Chronic Pain Syndrome, and Osteoporosis.</p> <p>Medical record review of the MDS dated January 5, 2012, revealed the resident required total assistance with transferring and used a mechanical lift to transfer.</p> <p>Medical record review of the resident's care plan dated October 22, 2010, and revised on January 5, 2012, revealed "... I have difficulty with mobility...I require extensive assist w/ADLs (activities of daily living) daily...I have Range of Motion (ROM) and mobility deficits..." Continued review of the resident's care plan revealed no documentation the care plan identified and addressed the resident's transfer status requiring the use of the sit-to-stand mechanical lift.</p> <p>Interview with resident #15 on January 23, 2012, at 4:30 p.m., in the resident's room confirmed the resident transferred using a mechanical lift.</p> <p>Interview on January 25, 2012, at 10:45 a.m., in the hallway with the Physical Therapy Assistant confirmed the resident used a sit-to-stand lift for transfers.</p> <p>Interview on January 26, 2012, at 10:45 a.m. in the conference room with the Assistant Director of Nursing/MDS Coordinator confirmed the sit-to-stand lift had not been addressed on the resident #15's care plan.</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>Resident #31 was admitted to the facility on September 25, 2006, with diagnoses including Alzheimer's Disease, Macular Degeneration, Osteoporosis, Arthropathy, Anxiety, and Depressive Psychosis Severe.</p> <p>Medical record review of the Minimum Data Set (MDS) dated November 14, 2011, revealed the resident had impaired short and long term memory, required total assistance with transfers, eating, bathing, toileting, and was non-ambulatory.</p> <p>Medical record review of the resident's care plan dated June 3, 2010, and revised on November 14, 2011, revealed the resident used a wheel chair with a lap buddy.</p> <p>Observation on January 23, 2012, at 11:20 a.m., and 4:50 p.m., in the dining room revealed the resident sitting in a reclined geriatric (Geri) chair.</p> <p>Interview on January 25, 2012, at 3:46 p.m., outside of the resident's room with Home Household Coordinator #4 confirmed the resident was changed from a wheel chair and lap buddy to use a reclining Geri chair the week before.</p> <p>Interview on January 26, 2012, at 10:45 a.m., in the conference room with the MDS Coordinator confirmed the resident's care plan had not been revised to reflect the resident used a reclining Geri chair instead of the wheel chair and lap buddy.</p> <p>Medical record review for Resident #23 documented an admission date of February 22, 2005 with diagnoses of Bipolar Disorder,</p>			F 280			

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F 280	<p>Continued From page 8</p> <p>Schizophrenia, Neuropathy, Osteoarthritis, and Congestive Heart Failure.</p> <p>The Fall Risk Assessment dated August 11, 2011 documented a total score of 11 and on November 3, 2011 a total score of 16. "...Score of 10 or more = high risk..."</p> <p>Review of the Nurse's Notes dated September 24, 2011 documented Resident #23 experienced a fall while getting up from the bed unassisted. "...ACTIONS...Non-skid footwear on when out of bed..."</p> <p>Review of the Nurse's Notes dated January 12, 2012 and January 13, 2012 documented Resident #23 experienced a fall when using the bathroom unassisted. "...ACTIONS...Keep bed at a comfortable level..."</p> <p>Review of the current care plan dated January 23, 2012 revealed there were no new/different interventions implemented after the falls on September 24, 2011, January 12, 2012, or January 13, 2012.</p> <p>During an interview in the conference room on January 26, 2012 at 2:10 pm, the Director of Nursing (DON) was asked if the care plan included new/different interventions after the fall on September 24, 2011, January 12, 2012, and January 13, 2012. The DON stated, "I don't see anything different. No."</p> <p>Medical record review for Resident #43 documented an admission date of August 14, 2008 with diagnoses of Alzheimer's Disease, Hypertension, Lumbago, and Abnormality of Gait.</p>	F 280			

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F 280	Continued From page 9  Review of the Nurse's Notes dated January 7, 2012 documented Resident #43 experienced a fall in the living room beside the fireplace. The Nurse's Notes documented, "...ACTIONS: Body alarm placed/continued, gel cushion placed in wheelchair to prevent sliding..."  Review of the current care plan dated January 17, 2012 had no documentation of the intervention of the gel cushion.  Observations in the living room on January 25, 2012 at 8:05 am and on January 26, 2012 at 10:23 am, revealed Resident #43 seated in a wheelchair with a gel cushion.  During an interview in the MDS office on January 26, 2012 at 3:20 pm, Nurse #3 was asked if the care plan for resident #43 included the gel cushion. Nurse #3 reviewed the care plan and stated, "No, I don't see it. She (Resident #43) has the gel cushion in a chair all the time now."	F 280			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	A 72 hour incontinent assessment will be completed by the LPN and CNA for resident #44 on 2-12-12. Urinary patterns will be determined and resident will be started on an appropriate bladder maintenance or retraining program.  An audit will be completed by the LPN's on 2-12-12 to identify any resident with a change and/or decline in continence. A 72 hour		2-12-12

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F 315	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to provide an incontinence management program to maintain the resident's highest level of functioning for one resident (#44) of one sampled resident for incontinence of twenty-three residents reviewed in Stage 2.</p> <p>The findings included:</p> <p>Resident #44 was admitted to the facility on September 13, 2011, with diagnoses including Urinary Frequency, Atrial Fibrillation, Glaucoma, and Edema.</p> <p>Review of the admission Minimum Data Set (MDS) dated September 26, 2011, revealed the resident was occasionally incontinent of urine defined by the MDS as having less than seven episodes of urinary incontinence during the assessment period.</p> <p>Review of the quarterly MDS dated December 20, 2011, revealed the resident had frequent urinary incontinence during the assessment period defined by the MDS as having seven or more episodes of urinary incontinence but at least one episode of continence.</p> <p>Review of the facility policy, Continence Care Management Program, revealed, "...All residents who are incontinent on admission or develop incontinence will be assessed by a registered nurse using the MDS, the Urinary Incontinence RAP (Resident Assessment Protocol), and the restorative nursing toileting assessment...The</p>	F 315	<p>Continued from page 10</p> <p>incontinence assessment will be completed by 3-1-12 and appropriate interventions initiated on all residents found to have a change in bladder continence.</p> <p>The DON, ADON and SDC will complete education to RN/LPN/CNA staff by 3-1-12 on reporting and documentation of changes in bladder continence. The MDS coor. will reassess all residents at admission, quarterly and with any significant change in condition including but not limited to change in continence to ensure that resident's functional capacity is met and maintained.</p> <p>Any resident having a significant change in condition including urinary continence will be presented at the monthly QAA meeting to ensure appropriate assessments were completed and interventions were initiated in a timely manner.</p> <p>A wound assessment was completed for resident #12 on 1-31-12 by the LPN. The DON educated Home 1 LPN's on 2-9-12 re: weekly wound</p>	3-1-12	3-1-12

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F 315	Continued From page 11 information from these assessments will be used to determine the type of program that will assist the resident to regain continence or reduce the incidence of incontinence..."			F 315	continued from page 11 assess., schedules and proper doc. of wounds. An audit was done for all residents with wounds was completed 2-8-12 by LPN's to ensure all assess. were current and complete. Education of staff will be done by 3-1-12. Assess. sch- dules will be monitored by DON. Wounds will be presented at QAA.		2-9-12 2-8-12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observations, and interview it was determined the facility failed to implement interventions to prevent accidents such as falls for 1 (#23) of 4 sampled residents reviewed of the 23 residents in Stage 2.  Medical record review for Resident #23 documented an admission date of February 22, 2005 with diagnoses of Bipolar Disorder, Schizophrenia, Neuropathy, Osteoarthritis, and Congestive Heart Failure.  The Fall Risk Assessment dated August 11, 2011 documented a total score of 11 and on			F 323	Resident #23 Careplan was reviewed 2-9-12 by the MDS coordinator to ensure all current fall interventions were appropriate and in place.  A 10% weely chart audits on all residents will be com- pleted by the DON, MDS Coor. and RN supervisor to ensure appropriate fall interven- tions are current.  All fall reports will be reviewed daily in AM meetings. to ensure timely implementa- tion of appropriate fall interventions. RN's/LPN's will be educated by 3-1-12 on post fall interventions.  All resident's falls will be reviewed monthly in QAA to ensure appropriate interven- tions are being initiated immediately following any fall.		3-1-12 2-9-12 3-1-12

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F 323	Continued From page 12 November 3, 2011 a total score of 16. "...Score of 10 or more = high risk..."  Review of the facility's "Falls Policy - when a fall occurs at [named] Nursing Home" policy documented, "...Staff involved with fall to do a learning circle/huddle on the day of occurrence or next scheduled day to discuss pattern, reasons, or needed interventions to prevent further falls for the resident...Life safety measure implemented will be added to the Care Plan..."  Review of the Nurse's Notes dated September 24, 2011 documented Resident #23 experienced a fall while getting up from bed unassisted.  Review of the Nurse's Notes dated January 12, 2012 and January 13, 2012 documented Resident #23 experienced a fall when using the bathroom unassisted.  Review of the current care plan dated January 23, 2011 revealed there were no new/different interventions implemented after the falls on September 24, 2011, January 12, 2012, or January 13, 2012.  During an interview in the conference room on January 26, 2012 at 2:10 pm, the Director of Nursing (DON) was asked if the care plan included new/different interventions after the fall on September 24, 2011, January 12, 2012, and January 13, 2012. The DON stated, "I don't see anything different. No."	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive	F 325	Resident #31 was fed by CNA. 1-25-12 Resident records will be reviewed by RN and LPN charge nurses to determine residents requiring assistance with feeding. Staff will be		

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F 325	<p>Continued From page 13</p> <p>assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, observation, and interview, the facility failed to provide assistance with meals for one nutritionally at risk resident (#31) of twenty-three residents reviewed in Stage 2.</p> <p>The findings included:</p> <p>Resident #31 was admitted to the facility on September 25, 2006, with diagnoses including Alzheimer's Disease, Macular Degeneration, Paranoid State, and Anxiety.</p> <p>Medical record review of the Minimum Data Set dated November 14, 2011, revealed the resident had impaired short and long term memory, and was totally dependent for eating. Medical record review of the resident's care plan revised on November 14, 2011, revealed "...I am at risk for Alteration in nutrition (less than body requirements) secondary to Decreased appetite...I need assistance...I have a hx (history) of weight decline..."</p>	F 325	<p>continued from page 13</p> <p>assigned responsibility for assisting specific residents at each meal.</p> <p>Household Coordinators will educate staff regarding and assist to feed responsibilities by 3-1-12. The Administrator, DON, ADON and/or staff development coordinator will observe at least 1 meal per day x 10 days, then 1 meal per week x 10 days on various shifts to ensure adequate assistance is being provided.</p> <p>Continue weekly monitoring of meals. DON will present results of ongoing monitoring at monthly QAA meeting.</p>		3-1-12

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F 325	Continued From page 14 Observation on January 25, 2012, at 5:05 p.m., in the dining room revealed the resident seated in the geri-chair at the table, was served a pureed meal in multiple bowls. Continued observation from 5:05 p.m. to 5:20 p.m., revealed the resident did not attempt to feed self but sat with the bowls of food on the table in front of the resident. Continued observation revealed a Certified Nurse Assistant (CNA) #3 sat across from resident #31 feeding another resident. Continued observation revealed the Culture Change/Staff Development Coordinator sat down next to resident #31 at 5:08 p.m., and assisted the resident sitting next to resident #31, and did not assist resident #31. Continued observation revealed the administrator came into the dining room at 5:10 p.m., and sat at another table within view of resident #31, and assisted a resident that needed cueing to eat.  Interview on January 25, 2012, at 5:20 p.m., with the Culture Change/Staff Development Coordinator and CNA #3 confirmed resident #31 required assistance to eat, and no one had offered to assist the resident.	F 325			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to administer seven of fifty-four medications observed for administration resulting in a 12.96% medication	F 332	The deficient practice was reviewed with Nurse #2 by the DON. Nurse #2 was educated on following medication orders including giving medication with meals. The deficient practice was discussed with Nurse #1 by the DON. Nurse #1 was educated on importance and techniques of ensuring that residents with crushed medications in liquid receive all of their medications as	1-27-12	

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F 332	<p>Continued From page 15 error rate.</p> <p>The findings included:</p> <p>Medical record review of resident #5's January 2012, recapitulation of physician's orders revealed "...Glimepiride 2 mg (milligram) tablet by mouth b.i.d. (two times per day) 07:00 am 05:00 pm (with breakfast and supper)..."</p> <p>Observation on January 25, 2012, at 4:05 p.m., in resident #5's room revealed Licensed Practical Nurse (LPN) #2 administered Glimepiride 2mg tablet by mouth to resident #5.</p> <p>Interview on January 25, 2012, at 4:19 p.m., with LPN #2 outside of the resident's room revealed resident #5 would eat supper in approximately 25 minutes and confirmed the medication was ordered to be given with supper resulting in one medication error.</p> <p>Medical record review of resident #49's January 2012, recapitulation of physician's orders revealed "...Celexa 40 mg tablet by mouth (1) daily...Buspar 5mg tablet by mouth b.i.d...Hydrochlorothiazide 25 mg tablet by mouth daily...Seroquel 25 mg (1) po b.i.d...Hydrocodone 10/500mg (1) t.i.d (three times a day)...K-DUR (potassium) 10 meq (millequivalents) (1) po b.i.d ..."</p> <p>Observation on January 26, 2012, at 8:35 a.m., in resident #49's room revealed LPN #1 crushed the Buspar, Hydrochlorothiazide, Seroquel, and Hydrocodone, poured the crushed medication into a medication cup and added approximately twenty-five milliliters of juice. Continued</p>	F 332	<p>continued from page 15 ordered.</p> <p>The staff development coor. will complete education with RN's and LPN's on giving medications with meals and the proper way of administering crushed medications in liquids.</p> <p>DON/ADON/SDC will complete monthly review of nurses performances re: following medication orders, giving medications with meals and proper administration of crushed medications with liquids for 3 consecutive months until proficiency is determined.</p> <p>SDC will present results of monthly audits of nurses performance giving medications with meals and crushed medications in liquids to the QAA committee for 3 months.</p>	3-1-12	

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F 332	Continued From page 16 observation revealed LPN #1 opened the K-DUR capsule into the medication cup, and administered the medications to the resident using a straw. Continued observation revealed the resident took one sip of the medication/juice mixture and had approximately 7.5 ml remaining. Continued observation revealed LPN #1 threw the cup with the remaining medication/juice mixture into the trash.  Interview on January 26, 2012, at 8:45 a.m., in the resident's room/bathroom with LPN #1 confirmed approximately 7.5 ml of medication/juice mixture remained in the medication cup, and the resident had not received all of the medication as ordered.	F 332			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview, it was determined the facility failed to ensure that food was prepared and served under sanitary conditions as evidenced by staff using a glass to scoop ice, placing the ice scoop in the ice container, and not practicing proper	F 371	All staff will be inserviced on the proper use of ice scoops. Continued monitoring by Dietary Manager, Household Coordinators and Household LPN. Annual inservice for existing staff on use of ice scoop and replacing scoop to proper storage place after each use, the importance of sanitary practices and possible hazards of not using sanitary practices. New staff will also be trained on proper use and storage of ice scoop, sanitary practices and possible hazards of improper use and storage. CDM, Household Coord., LPN's and lead cooks will monitor	2-17-12	

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F 371	<p>Continued From page 17</p> <p>handwashing with the use of gloves on 2 of 4 days food service was observed.</p> <p>The findings included:</p> <p>Observation on January 23, 2012, at 12:10 p.m., in the Lake Home food serving area, revealed Certified Nurse Assistant #1 with bare hands took a plastic glass, opened the ice container, used the plastic glass to scoop ice into the glass, closed the ice container and gave the glass of ice to a resident.</p> <p>Interview with the Dietary Manager on January 26, 2012, at 9:35 a.m., at the Munson home kitchen area confirmed the plastic glass was not to be used as an ice scoop.</p> <p>Observation on January 25, 2012, at 5:00 p.m., of the meal service prepared in the Munson home revealed the dining services staff opened the ice dispenser, and removed the ice scoop from the ice in the ice bin.</p> <p>Interview with the Dietary Manager on January 26, 2012, at 9:35 a.m., at the Munson home dining room confirmed, the ice scoop should not have been stored in the ice bin. Continued interview confirmed the scoop was to be placed in the holder on the side of the ice container.</p> <p>Review of the facility's "Preventing Contamination of Food during Preparation and Serving" policy documented, "...Hands will be washed before putting on gloves and after disposal of gloves..."</p> <p>Observations in the dining area of #4 Home on January 25, 2012 at 5:08 pm, Dietary</p>	F 371	<p>continued from page 17</p> <p>use of scoops during meal times and food service activities. Dietary manager and lead cooks will monitor proper ice scoop storage during weekly inventory checks.</p> <p>Dining services staff were inserviced on the policy and procedure on handwashing with the use of gloves on 2-10-12</p> <p>Staff preparing or serving food in the homes will be inserviced at least annually with Registered Dietician and CDM on proper handwashing with the use of gloves and the importance of sanitation during food prep. CDM and lead cooks will monitor for proper handwashing with the use of gloves durin food prep and service. CDM will monitor proper handwashing during meals and food service activities. If the staff member fails to do the procedure correctly they will have a one on one training and disciplined if necessary. 2-10-12</p>		

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F 371	Continued From page 18 Services/CNA prepared a plate of food, removed her gloves, did not wash the hands, and put on a clean pair of gloves. The Dietary Services/CNA stated while putting on clean gloves, "I can't get these gloves on. My hands are sweaty." He/she then put the gloves on and served the meal to a resident, removed the gloves and did not wash the hands. He/she put on gloves, placed cookies on saucers and served the cookies to the residents. The Dietary Services/CNA did not wash his/her hands before putting on gloves or after removing the gloves.	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to identify irregularities for physician's orders for one (#31) of twenty-three residents reviewed in Stage 2.  The findings included:  Resident #31 was admitted to the facility on September 25, 2006, with diagnoses of	F 428	Medication orders for resident #31 were clarified as follows: APAP 500mg tablet PO bid PRN with start date of 1-25-12.  An audit of all Tylenol/acetamenophen/APAP orders will be completed by DON and Pharmacist consultant by 2-15-12.  All physicians orders including medication orders will be reviewed daily at AM meetings to identify and correct any potential medication discrepancies.  DON will present audit results of Tylenol/aceta-minophen/APAP orders at QAA meetings. Pharmacy consultant will maintain monthly DRR and present any related	1-25-12  2-15-12	

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F 428	Continued From page 19 Alzheimer's Disease, History of Colon Cancer, Macular Degeneration, Osteoporosis, Arthropathy, Anxiety, Senile Delusion, Diverticulosis, Paranoid State, and Depressive Psychosis Severe.  Medical record review of the January 2012, recapitulation physician's orders revealed: "...05/13/2011...Acetaminophen (generic Tylenol) 500MG (milligrams) Tablet by mouth q. (every) 6 hr. (hours) p.r.n. (as needed) Not to exceed 4000MG/24hr. For: Pain...05/22/2011 A.P.A.P. (Acetaminophen) 500MG Tablet by mouth q. 4hr. p.r.n. For: Pain (DO NOT EXCEED 4000MG)... Acetaminophen 650MG Suppository rectal (use if unable to ingest tablet) q.6 h.(hours) p.r.n... A.P.A.P. 500MG Tablet by mouth q.i.d. (four times per day)..." Continued review revealed the physician's orders had overlapping dosages with potential for excessive ingestion of the medication.  Interview and review of the physician orders with resident #31's physician on January 25, 2012, at 9:30 a.m., in the nurse's station confirmed the resident had four separate orders for Acetaminophen. Continued interview confirmed the physician stated had "missed that."  Interview on January 25, 2012, at 2:30 p.m., in the hallway near the conference room with the Director Of Nursing confirmed the consulting pharmacist had not reported any medication irregularities or made any medication recommendations on the monthly reports for resident #31 since July 2011.	F 428	continued from page19 concerns immediately to DON and at monthly QAA meetings.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	The deficient hand washing technique was reviewed with Nurse #3 by the DON on 1-27-12		

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NAME OF PROVIDER OR SUPPLIER  <b>WHARTON NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>55 WEST LAKE ROAD PLEASANT HILL, TN 38578</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 21</p> <p>by:</p> <p>Based on policy review, observation and interview it was determined the facility failed to ensure practices to prevent the potential spread of infection was maintained when a nurse failed to properly wash her hands after 1 of 1 dressing change.</p> <p>The findings included:</p> <p>Review of the facility's "Washing Hands with Soap and Water" policy documented, "...Procedure: 1. Wet hands with warm running water. 2. Apply hand washing soap and distribute over hands. 3. Vigorously rub hands together 20 seconds, generating friction on all surfaces of the hands and fingers...4. Rinse hands thoroughly to remove residual soap...5. Turn off water with a paper towel. 6. Dry hands thoroughly and dispose in wastebasket..."</p> <p>Observations in room 104 on January 26, 2012 at 10:55 am, revealed Nurse #3 put on gloves and gathered supplies for a dressing change. Nurse #3 placed the supplies on the table and then removed the gloves. Nurse #3 put on three pairs of gloves, repositioned the resident in bed, removed the old dressing from the resident's right buttock, then removed one pair of gloves. Nurse #3 packed the wound, cut the gauze packing strip with scissors and placed the scissors on the pad on the bed. Nurse #3 removed a second pair of gloves. Nurse #3 applied the clean dressing to the wound and then removed a third pair of gloves. Nurse #3 put on clean gloves, dated another gauze dressing and placed over the wound. Nurse #3 then removed the pair of gloves and kept the pair of scissors inside one of the</p>	F 441		

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F 441	Continued From page 22 gloves. Nurse #3 picked up the red trash bag and continued holding the dirty glove with scissors in her left hand and carried the trash bag while holding the dirty glove and scissors into the bio-hazard room. Nurse #3 placed the trash bag into the trash container and continued to hold the dirty glove and scissors. Nurse #3 wet her right hand and attempted to wash the one hand. Nurse #3 left the bio-hazard room and went into the nurse's station and placed the dirty glove and the scissors into the sink. Nurse #3 then washed the hands.  During an interview in the nurse's station on January 26, 2012 at 11:30 am, Nurse #3 was asked why did she wear three pairs of gloves and did not wash her hands after the use of gloves. Nurse #3 stated, "I didn't want to walk away and turn my back on the table and I didn't have hand sanitizer with me. Normally I would use the hand sanitizer when taking off the gloves."  During an interview in the nurse's station on January 26, 2012 at 11:33 am, Nurse #3 was asked what is the proper handwashing procedure. Nurse #3 stated, "Wash your hands thoroughly, provide friction up to your wrists and rub in between your fingers for 20 seconds with hot water, rinse, dry your hands, and turn water off with another towel. I attempted it with one hand." Nurse #3 confirmed she did not properly wash her hands.	F 441			
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT  The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	Residents who have used the handicapped restroom in the hallway will be redirected to their rooms.  Residents who attempt to use the visitor handicapped		2-10-12

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F 465	Continued From page 23 residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide a safe environment in common areas by not providing an emergency call system for 2 of 2 handicapped restrooms/bathrooms.  The findings included:  Observations on January 23, 2012 at 2:15 pm, revealed the handicapped restroom across from the Spa in Brauhn Home was unlocked and there was no emergency call system installed.  Observations on January 23, 2012 at 3:05 pm, revealed the handicapped restroom across from the Spa in Lake House was unlocked and there was no emergency call system installed.  During an interview in the hallway outside the handicapped restroom in Lake Home on January 24, 2012 at 8:18 am, Certified Nursing Assistant (CNA) #2 was asked if any residents use the handicapped restrooms. CNA #2 stated, "Yes, we have 2 or 3 that use it at times." CNA #2 confirmed there was no emergency call system in the restroom and the door is kept unlocked.	F 465	continued from page 23 restroom in the hallway will be redirected to their room.  The handicapped restroom will be kept locked and residents will be redirected to their room.  A sign will be put on the handicapped visitors rest- room stating "Visitors Rest- room. Keep door locked" and the door will be checked daily by staff to ensure that it is locked.		2-10-12 2-10-12 2-10-12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIB LE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514	The current weekly wound assessment for resident #12 was reviewed on 1-27-12 to ensure accuracy of documen- tation.  The DON will audit all weekly		1-27-12

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F 514	<p>Continued From page 24 accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure the medical records were maintained accurately and completely for skin/wound assessments for 1 (#12) of 23 sampled residents reviewed of the 23 residents in Stage 2.</p> <p>The findings included:</p> <p>Medical record review for Resident #12 documented an admission date of August 18, 2003 and a readmission date of May 31, 2011 with diagnoses of Parkinson's Disease, Pressure Ulcer, Hypothyroidism, Osteoporosis, Esophageal Reflux, and Constipation.</p> <p>Review of a physician's order dated November 16, 2011 documented, "...Cleanse wound with wound cleaner; pack inner wound with Iodoform packing strip; Apply Triad ointment around outer edges; cover with Optifoam non-adhesive; secure with medipore tape; Change daily AM and as needed..."</p> <p>Review of the Nurse's Notes dated June 1, 2011</p>	F 514	<p>Continued from page 24 wound assessments by 2-15-12 for accuracy.</p> <p>The DON will educate RN's/ LPN's on proper, accurate and complete documentation of weekly wound assess- ments by 3-1-12. Ongoing audits of weekly wound assessments by the DON will continue for 3 months.</p> <p>Findings of weekly wound assessment audits will be presented to the QAA com- mittee monthly for 3 months or until the deficient practice is corrected.</p>	<p>2-15-12</p> <p>3-1-12</p>	

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F 514	<p>Continued From page 25</p> <p>documented Resident #12 had an area on the right buttock described as, "scuffed off broken skin measuring 1/4 by 1/4..."</p> <p>Review of the Nurse's Notes dated June 7, 2011 documented, "SKIN PROBLEMS: Has no skin problems or lesions present in past 7 days...PRESSURE ULCER: no pressure ulcers..."</p> <p>Review of the Nurse's Notes dated June 12, 2011 documented, "PRESSURE ULCERS: Partial thickness loss of skin layers that presents as an abrasion or blister (Pressure Stage 2)..."</p> <p>During an interview in the conference room on January 25, 2012 at 11:15 am, The Staffing Development Coordinator reviewed the Nurse's Notes dated June 7, 2012 and stated, "That's an error. That's not accurate. [Resident #12] had the pressure ulcer since...back on the 31st [May 31, 2011]. I don't know why the nurse documented...no skin problems and no pressure ulcer."</p>	F 514			

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